

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1895

CERTIFICATE OF DEATH

01909

Reg. Dist. No. 207

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>235 Lynchburg St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James Thomas Bowers</u>				4. DATE OF DEATH <u>Feb. 25, 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1, 1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Farmer & Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Kent CO. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James H. Bowers</u>				14. MOTHER'S MAIDEN NAME <u>Edell Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>222-05-3650</u>		17. INFORMANT <u>Lucy S. Bowers</u> Address: <u>235 Lynchburg St. Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Murder Hemoptysis</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma of lung metastasis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diagnosis at Surgery 8/8/56</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/10, 1956</u> , to <u>2/24, 1957</u> , that I last saw the deceased alive on <u>2/24, 1957</u> , and that death occurred at <u>6 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>Feb. 25, 1957</u>							
ACTUAL SIGNATURE <u>Thomas J. Solon</u> M.D. <u>Chestertown, Md.</u>				PHYSICIAN'S NAME (Type) <u>Thomas J. Solon</u> <u>Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Coleman's (Col.)</u>		22d. LOCATION (City, town, or county) (State) <u>near - Still Pond, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u>				24a. REC'D BY REGISTRAR <u>Feb 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU OF HEALTH

FEB 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01910

1896

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD # 2</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ Chestertown</u>			
f. STREET ADDRESS <u>RFD #2</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>T. Lester Bowers</u>				4. DATE OF DEATH Month Day Year <u>Feb. 6, 1957</u> <u>19</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 11, 1887</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James R. Bowers</u>				14. MOTHER'S MAIDEN NAME <u>Mary Smythe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-20-6125</u>		17. INFORMANT <u>Thomas Bowers</u> Address <u>RFD # 2 Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>							<u>4 1/2 hours</u>
331X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) <u>Hypertension</u>							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 6/</u> , 19 <u>57</u> , to <u>Feb 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 6</u> , 19 <u>57</u> , and that death occurred at <u>10:40 p.m.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>E. Kester</u> M.D. <u>Rock Hall</u>							
PHYSICIAN'S NAME (Type) <u>Eugene Kester</u> <u>Rock Hall, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 10, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Wells</u> ADDRESS <u>Chestertown, Md.</u>				24. REC'D BY REGISTRAR <u>Feb. 11-1957</u>		24b. REGISTRAR'S SIGNATURE <u>Clara J. Barnes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01911

1902

CERTIFICATE OF DEATH

Reg. Dist. No.

703

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> (Several Years)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rock Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth</u> <u>Edwards</u> <u>Cowperthwaite</u>		4. DATE OF DEATH Month Day Year <u>Feb. 16, 1957</u> <u>19</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1898</u>
9. AGE (In years last birthday) yrs. <u>58</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Phila., Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Birmingham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-20-0020</u>	
17. INFORMANT <u>James Cowperthwaite</u>		Address <u>Rock Hall, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast & metastases</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>170X</u> DUE TO (c) <u>170X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 28, 1956</u> , to <u>Feb 16, 1957</u> , that I last saw the deceased alive on <u>Feb 16, 1957</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Rock Hall</u>	
DATE SIGNED <u>2/16/57</u>			
PHYSICIAN'S NAME (Type) <u>Willard F. Smith</u>		<u>Rock Hall, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 18, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>near - Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wells</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>S. Elwood Burgess</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 19 1957

RECEIVED

1897 CERTIFICATE OF DEATH

Reg. Dist. No. 5203

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT + QUEEN ANNE Co. Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>NELSON</u> Last <u>CULLEY SR.</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>27</u> Year <u>1957</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 4 - 1900</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>WM. CULLEY</u>				14. MOTHER'S MAIDEN NAME <u>MARY HARRISON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-147834</u>		17. INFORMANT <u>James N. Culley Jr.</u>		Address <u>Rock Hall</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1952</u> to <u>Feb. 27, 1957</u> , that I last saw the deceased alive on <u>Feb. 26, 1957</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard F. Smith</u>		M.D. <u> </u>		ADDRESS (Street, city or town, state) <u>Rock Hall, Md</u>		DATE SIGNED <u>3/1/57</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 1</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar N. New</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	
				24b. REGISTRAR'S SIGNATURE <u>S. Elwood Binger</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 15

MAR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01913
Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>1903 Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>several years x1 Rural, Chestertown, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural - home</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Marie</u> Last <u>Doll</u>		4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/8/1902</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Chicago, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Arvid Gustafson</u>		14. MOTHER'S MAIDEN NAME <u>Mathilda Swanson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>360-05-1281</u>	
17. INFORMANT Address <u>Carl Doll, Jr., Chestertown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>shot gun wound - upper abdomen</u> Instantaneously <u>976x</u> DUE TO <u>self-inflicted</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Gross injury in arm, wound to back of head and fired shot gun into upper abdomen</u>	
20c. TIME OF INJURY Month, Day, Year <u>1002</u> Hour <u>a. m.</u> <u>2/20</u> <u>19 57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Chestertown Kent Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Robert W. Farr</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Robert W. Farr, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Feb. 21, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		24a. REC'D BY REGISTRAR <u>Feb. 23-57</u>	
ADDRESS <u>Chestertown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER		13. SIGNATURE OF WITNESS		14. SIGNATURE OF JURY		15. SIGNATURE OF CORONER	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF NURSE		20. SIGNATURE OF CHURCH	
21. SIGNATURE OF MINISTER		22. SIGNATURE OF RABBI		23. SIGNATURE OF PRIEST		24. SIGNATURE OF BISHOP		25. SIGNATURE OF ARCHBISHOP	
26. SIGNATURE OF CARDINAL		27. SIGNATURE OF POPE		28. SIGNATURE OF DECEASED		29. SIGNATURE OF NEXT OF KIN		30. SIGNATURE OF PHYSICIAN	
31. SIGNATURE OF NURSE		32. SIGNATURE OF CHURCH		33. SIGNATURE OF MINISTER		34. SIGNATURE OF RABBI		35. SIGNATURE OF PRIEST	
36. SIGNATURE OF BISHOP		37. SIGNATURE OF ARCHBISHOP		38. SIGNATURE OF CARDINAL		39. SIGNATURE OF POPE		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF NEXT OF KIN		42. SIGNATURE OF PHYSICIAN		43. SIGNATURE OF NURSE		44. SIGNATURE OF CHURCH		45. SIGNATURE OF MINISTER	
46. SIGNATURE OF RABBI		47. SIGNATURE OF PRIEST		48. SIGNATURE OF BISHOP		49. SIGNATURE OF ARCHBISHOP		50. SIGNATURE OF CARDINAL	
51. SIGNATURE OF POPE		52. SIGNATURE OF DECEASED		53. SIGNATURE OF NEXT OF KIN		54. SIGNATURE OF PHYSICIAN		55. SIGNATURE OF NURSE	
56. SIGNATURE OF CHURCH		57. SIGNATURE OF MINISTER		58. SIGNATURE OF RABBI		59. SIGNATURE OF PRIEST		60. SIGNATURE OF BISHOP	
61. SIGNATURE OF ARCHBISHOP		62. SIGNATURE OF CARDINAL		63. SIGNATURE OF POPE		64. SIGNATURE OF DECEASED		65. SIGNATURE OF NEXT OF KIN	
66. SIGNATURE OF PHYSICIAN		67. SIGNATURE OF NURSE		68. SIGNATURE OF CHURCH		69. SIGNATURE OF MINISTER		70. SIGNATURE OF RABBI	
71. SIGNATURE OF PRIEST		72. SIGNATURE OF BISHOP		73. SIGNATURE OF ARCHBISHOP		74. SIGNATURE OF CARDINAL		75. SIGNATURE OF POPE	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF PHYSICIAN		79. SIGNATURE OF NURSE		80. SIGNATURE OF CHURCH	
81. SIGNATURE OF MINISTER		82. SIGNATURE OF RABBI		83. SIGNATURE OF PRIEST		84. SIGNATURE OF BISHOP		85. SIGNATURE OF ARCHBISHOP	
86. SIGNATURE OF CARDINAL		87. SIGNATURE OF POPE		88. SIGNATURE OF DECEASED		89. SIGNATURE OF NEXT OF KIN		90. SIGNATURE OF PHYSICIAN	
91. SIGNATURE OF NURSE		92. SIGNATURE OF CHURCH		93. SIGNATURE OF MINISTER		94. SIGNATURE OF RABBI		95. SIGNATURE OF PRIEST	
96. SIGNATURE OF BISHOP		97. SIGNATURE OF ARCHBISHOP		98. SIGNATURE OF CARDINAL		99. SIGNATURE OF POPE		100. SIGNATURE OF DECEASED	

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FEB 26 1957
BUREAU V. 1

STATE OF MARYLAND—BALTIMORE, 18

1898

Block 22 Film G211 2-28-57 et

CERTIFICATE OF DEATH

01914

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester Town</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 Chester Town</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent Queen Anne's Hosp.</u>				d. STREET ADDRESS <u>P.R. #2, Box 232</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Freeman</u>				4. DATE OF DEATH Month Day Year <u>February 18 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 18, 1957</u>		9. AGE (In years lost birthday) yrs. Months Days Hours Min. <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Arthur William Freeman</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Viola Pinkett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mother Chester Town, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/18/57</u> , 19 <u>57</u> , to <u>2/18/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/18/57</u> , 19 <u>57</u> , and that death occurred at <u>Rock Hall, Md</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Rock Hall, Md</u>			
PHYSICIAN'S NAME (Type) <u>Family</u>				DATE SIGNED <u>2/18/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Melitota</u>		22d. LOCATION (City, town, or county) (State) <u>Melitota, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Family</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>2-18-57</u>	
						24b. REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>	

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BUREAU V. S.

FEB 20 1957

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1904

CERTIFICATE OF DEATH

Reg. Dist. No.

201

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lynch</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Lynch</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Louis George</u>				4. DATE OF DEATH Month Day Year <u>February 17, 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May, 6, 1885</u>	9. AGE (In years last birthday) yrs. <u>71</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tenant Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicholas George</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Cox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-12-0370</u>		17. INFORMANT Address <u>Linwood George Lynch, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Pulmonary Disease</u> DUE TO <u>Cystic Disease and super-imposed</u> (c) <u>pneumonitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u> <u>at least 1 1/2 years</u> <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7/9</u> , 19 <u>55</u> , to <u>2/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/17</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> a.m., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>2-18-57</u>			
PHYSICIAN'S NAME (Type) <u>Robert W. Farr</u>				<u>Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Galena Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Galena, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>				ADDRESS <u>Still Pond, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2/18/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>E. Kennedy Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. F.

FEB 20 1957

RECEIVED

Victor W. Kennedy

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1899

CERTIFICATE OF DEATH

01916

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN				c. LENGTH OF STAY IN 1b 13 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First OUTSLEY Middle RINGGOLD Last				4. DATE OF DEATH FEB Month 9 Day 1957 Year			
5. SEX F	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 17, 1893	9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL STANLEY				14. MOTHER'S MAIDEN NAME RACHEL BUTLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address J. RINGGOLD WORTON, MD. R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STROKE & UREMIA 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) KIMMELSTIEL - WILSON DISEASE DUE TO (c) DIABETES MELLITUS INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2-3 years Don't know							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 1. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-26 , 19 57 , to 2-9 , 19 57 , that I last saw the deceased alive on 2-9 , 19 57 , and that death occurred at 3:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, MD DATE SIGNED 2/9/57							
ACTUAL SIGNATURE Robert W. Farr		M.D. Chestertown, MD					
PHYSICIAN'S NAME (Type) ROBERT W. FARR							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-12-57		22c. NAME OF CEMETERY OR CREMATORY FOUNTAIN CEMTY		22d. LOCATION (City, town, or county) (State) WORTON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Victor M. Kennedy				ADDRESS STILL POND, MD.		24a. REC'D BY REGISTRAR DATE 2/11/57	
				24b. REGISTRAR'S SIGNATURE E. Kennedy Jones			

1905

CERTIFICATE OF DEATH

Reg. Dist. No.

207

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) c. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN lb life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 2 (Georgetown)				d. STREET ADDRESS 1 RFD # 2			
3. NAME OF DECEASED (Type or print) First Albert Middle Scott, Jr. Last				4. DATE OF DEATH Month 2 Day 14 Year 1957			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1908	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm and other		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Scott, Sr.				14. MOTHER'S MAIDEN NAME Lula Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 2I8-I6-5I68		17. INFORMANT Gustavia Scott - Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Cardiomegaly of Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiomegaly of Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocarditis						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 20, 1956 to Feb 4, 1957 , that I last saw the deceased alive on Feb 3, 1957 , and that death occurred at 70 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert C. Nitsch M.D.				ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 2/5/57			
PHYSICIAN'S NAME (Type) Herbert C. Nitsch - Rock Hall, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Georgetown Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR Feb 11 1957 24b. REGISTRAR'S SIGNATURE Charles J. Barnes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		ATTORNEY	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MARRIED		JAN 15 1956		BALTIMORE, MARYLAND		JAN 30 1968		BALTIMORE, MARYLAND		HEART DISEASE	
PREVIOUS MARRIAGES		DATE OF PREVIOUS MARRIAGE		PLACE OF PREVIOUS MARRIAGE		DATE OF PREVIOUS DEATH		PLACE OF PREVIOUS DEATH		CAUSE OF PREVIOUS DEATH	
NONE		NONE		NONE		NONE		NONE		NONE	
EDUCATION		SCHOOLING		REMARKS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE	
HIGH SCHOOL		12		FEB 11 1968		JAMES EARL RAY		JAMES EARL RAY		FEB 11 1968	
FAMILY HISTORY		PARENTS		SIBLINGS		CHILDREN		GRANDCHILDREN		OTHER RELATIVES	
FATHER: JAMES EARL RAY, JR.		MOTHER: MARY ESTHER RAY		BROTHERS: JAMES EARL RAY, JR.		SISTERS: MARY ESTHER RAY		CHILDREN: JAMES EARL RAY, JR.		GRANDCHILDREN: JAMES EARL RAY, JR.	
OTHER RELATIVES: JAMES EARL RAY, JR.		MOTHER: MARY ESTHER RAY		BROTHERS: JAMES EARL RAY, JR.		SISTERS: MARY ESTHER RAY		CHILDREN: JAMES EARL RAY, JR.		GRANDCHILDREN: JAMES EARL RAY, JR.	

BUREAU V. S.

FEB 11 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1906

CERTIFICATE OF DEATH

01918

Reg. Dist. No. 203

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALVIN First LLOYD Middle SHRECK Last				4. DATE OF DEATH Feb. 8 Month 8 Day 1957 Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 30 - 1892	
9. AGE (In years last birthday) 64 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATER MAN		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Frank Shreck				14. MOTHER'S MAIDEN NAME C. Emma Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-22-0687		17. INFORMANT Mrs. Mary Shreck - Rock Hall, Ind. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) Arterio Sclerosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Feb. 8 , 19 57 , to Feb. 8 , 19 57 , that I last saw the deceased alive on Feb. 8 , 19 57 , and that death occurred at 7:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Norbert C. Nitsch				ADDRESS (Street, city or town, state) Rock Hall Maryland			
PHYSICIAN'S NAME (Type) NORBERT C. NITSCH				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/10/57		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Rock Hall Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane - Church Hill, Ind.				24a. REC'D BY REGISTRAR 2/10/57		24b. REGISTRAR'S SIGNATURE A. Elmer Burgess	

WISCONSIN STATE DEPARTMENT OF HEALTH—BATHING 18

1957 13 13

RECEIVED

1900 CERTIFICATE OF DEATH

Reg. Dist. No. 01919

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 2 1/2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Anne Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Nettie M. Middle Sutton Last		4. DATE OF DEATH Month Feb. Day 23 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1880
9. AGE (In years ^{Age at birthday} yrs.) 76		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Kent Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John W. Hersch	
14. MOTHER'S MAIDEN NAME Emily Stevens (Emily)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Linwood Sutton, Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 442x DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma right breast			INTERVAL BETWEEN ONSET AND DEATH 5 mos. not known not known
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-9 , 19 56 , to 2-23 , 19 57 , that I last saw the deceased alive on 2-23 , 19 57 , and that death occurred at 8:45 p. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A.C. Dick		ADDRESS (Street, city or town, state) Chestertown, Md.	
PHYSICIAN'S NAME (Type) A.C. Dick		DATE SIGNED 2-25-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 26, 19 57	22c. NAME OF CEMETERY OR CREMATORY Chester Cem.	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James W. Wells		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE FEB 27 1957
24b. REGISTRAR'S SIGNATURE Charles Barnes			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1901

CERTIFICATE OF DEATH

01920

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN 1b 2 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Betterton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				d. STREET ADDRESS *****		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Anderson Last Sykes			4. DATE OF DEATH Month February Day 21 Year 1957				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1875		9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Anderson			14. MOTHER'S MAIDEN NAME Henrietta Gordon				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ---		17. INFORMANT Address William Sykes Betterton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute left ventricular Failure DUE TO (c) Myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH 5 h 10 h 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive & arteriosclerotic C.V. Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 53 , to Feb , 19 57 , that I last saw the deceased alive on Feb 21 , 19 57 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Florence Deringer Joyce			M.D. Worton, Md.		DATE SIGNED 2/21/57		
PHYSICIAN'S NAME (Type) Florence Deringer Joyce			Worton Md				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/57		22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery		22d. LOCATION (City, town, or county) Still Pond, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy			ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE 2/25/57		
					24b. REGISTRAR'S SIGNATURE C. Howard Jones		

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
JAMES J. O'NEILL		Male		45		1882		New York City		Carpenter		Heart Disease		New York City		10:30 AM		J. J. O'NEILL		J. J. O'NEILL		J. J. O'NEILL	
13. PLACE OF INTERMENT		14. NAME OF CEMETERY		15. NAME OF MINISTER		16. NAME OF CHURCH		17. NAME OF FUNERAL HOME		18. NAME OF UNDERTAKER		19. NAME OF COFFIN		20. NAME OF CASK		21. NAME OF CASK		22. NAME OF CASK		23. NAME OF CASK		24. NAME OF CASK	
St. Patrick's Cemetery		St. Patrick's Cemetery		St. Patrick's Cemetery		St. Patrick's Cemetery		St. Patrick's Cemetery		St. Patrick's Cemetery		St. Patrick's Cemetery		St. Patrick's Cemetery		St. Patrick's Cemetery		St. Patrick's Cemetery		St. Patrick's Cemetery		St. Patrick's Cemetery	

BUREAU V. B.

FEB 27 1937

RECEIVED

Wm. J. O'NEILL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 6210 2-15-57 et

Reg. Dist. No.

01921

202

1. PLACE OF DEATH a. COUNTY KENT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown c. LENGTH OF STAY IN 1b 2-3 years Rural - Chestertown - X2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEVEN Middle BALDWIN Last TRICE		4. DATE OF DEATH Month Feb Day 6 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5-1888
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour - Baltimore Farm		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Trice		14. MOTHER'S MAIDEN NAME Martha Adkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 164-16-7879	
17. INFORMANT Leona A. George		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Felt indigestion about noon - found dead about 5 PM			INTERVAL BETWEEN ONSET AND DEATH 5 hours
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) ROBERT W. FARR		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. II, 1957	22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery
22d. LOCATION (City, town, or county) Chestertown, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR Feb. 9-1957		24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the office of the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FEB 11 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01922

Reg. Dist. No. 203

1908			
1. PLACE OF DEATH a. COUNTY <u>Hent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		c. LENGTH OF STAY IN lb <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Joseph Lawrence</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>(LONNIE)</u> First Middle Last <u>WHALAND</u>		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1903</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>5</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel</u>		14. MOTHER'S MAIDEN NAME <u>Evelene Everett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>1</u>		16. SOCIAL SECURITY NO. <u>220-12-2406</u>	
17. INFORMANT <u>Mildred Whaland</u>		Address <u>Rock Hall, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>929.8</u> DUE TO <u>Prostate drowning -</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____</p> <p>(c) _____</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH <u>same</u></p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drunk, disappeared yesterday about 5:30 pm found in water today noon</u>	
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>River shore</u>	20f. (City or town) <u>Rock Hall</u> (County) <u>Hent</u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Robert W. Farr</u>		DATE SIGNED <u>2/9/57</u>	
EXAMINER'S NAME (Type) <u>ROBERT W. FARR</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) <u>Rock Hall</u> (State) <u>md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar S. Lane</u>		24a. REC'D BY REGISTRAR <u>2/12/57</u> 24b. REGISTRAR'S SIGNATURE <u>S. Edward Bringer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAKING STATEMENTS OUT OF HEALTH-BALANCE

FEB 18 1957

RECEIVED

1909

CERTIFICATE OF DEATH

Reg. Dist. No.

200

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millington</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chesterville Forest RFD 2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Eliza</u> Last <u>Woodland</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 25, 1881</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Janie Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Henrietta Burke</u> Address <u>RFD #2 Millington, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Degeneration of heart muscle -</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>for years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 2</u> , 19 <u>57</u> , to <u>Feb. 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 2</u> , 19 <u>57</u> , and that death occurred at <u>6:30 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Geza Koralewski</u> M.D. <u>Millington, Md.</u>				DATE SIGNED <u>Feb. 3, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Geza Koralewski</u> <u>Millington, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 7 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Morgnac Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>nr. Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 6 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elij. Mulford</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 6 1957

RECEIVED